

SUSAN WEBB, MD

New patient intake

Please complete this form and return it before your first appointment. Take your time — every health question is optional; share only what feels right.

Contact details

Full legal name

Preferred name (optional)

Date of birth

Email address

Phone number

Home address

Emergency contact

Emergency contact name

Their relationship to you

Their phone number

How did you hear about Susan Webb, MD?

Medical history

Every question here is optional. Share only what feels right.

Do you have any current health conditions? Please describe them.

Have you received mental health treatment or hospital care in the past? If so, please share what feels comfortable.

Is there any relevant family medical or mental health history?

Do you have any allergies (medications, foods, or other)?

Have you had any previous experience with psychedelic medicines? If so, please describe.

Medications & supplements

List each medication or supplement you take. For supplements, write “self” as the prescriber.

Name	Strength (e.g. 50 mg)	How often you take it	Prescriber (or “self”)

Consent & signature

Please read each statement and initial the box to agree.

- ☐ I confirm that the information I have provided is accurate and complete to the best of my knowledge.
- ☐ I have read and agree to the practice policies of Susan Webb, MD.

- ☐ I understand and agree to the practice's appointment and cancellation policy which requires 48 business hours' notice to cancel a scheduled appointment without incurring a cancellation fee of \$200.
- ☐ I agree that Susan Webb, MD may contact me by email or phone about my care and appointments.

Signature

Date
